BALANCING PRIVATE AND PUBLIC SECTOR ROLES
EXECUTIVE SUMMARY

Government regulation is one of many tools for making the health care system function effectively to ensure high quality, cost-effective care to Californians. Purchasers and competitors driven by consumer preferences based on information and appropriate incentives also regulate the industry as does the industry itself through self-regulation. By recognizing the strengths and weaknesses of other mechanisms, government can more effectively direct its efforts to intervene when and where needed to achieve desired goals.

PURCHASERS AND COMPETITORS: REGULATORS OF FIRST RESORT

In general in our society, we look to responsible purchasers and competing sellers to allocate resources. We associate competition with quality improvement, customer service, cost reduction, and desirable innovation. Cost and access to doctors and specialists of one's choice are two clear examples of where large purchasers have had success. Well-organized, large purchasers–including governments–have significant tools to make the market work better for consumers–tools that they have used only to a limited degree so far.

Market Failure and the Need for Collective Action

Health care and health insurance markets work better today than several years ago, particularly for large employers and purchasing coalitions. Nevertheless, these markets have many characteristics, including the incentive effects of insurance, the high cost of information, and wide variations in medical risks, that make them prone to failure, especially in the small group and individual market.

Any realistic discussion of regulation of health insurance and health services must be in the context of widely supported social goals: insurance should be widespread, if not universal, affordable, and its distribution should be tolerably equitable.

In the California market, two important reasons that purchasers and competitors are not better serving covered employees are (1) a lack of relevant information for providers, purchasers, payors, and consumers, and (2) a lack of choice, for many consumers,

It is important to keep in mind that even if collective action could fix all existing market failures, some people would still be unsatisfied with the outcome, especially because of limitations of medical technology and the fact that insurance limits their financial responsibility.

INDUSTRY SELF-REGULATION

The HMO industry needs public confidence. The wiser of its leaders recognize this. The industry, on its own initiative, or in response to problems identified by employers, consumers, and regulators ought to develop improved industry standards. Areas calling for improved standards include a better definition of covered emergency treatment, more reliable and effective appeals processes in case of treatment denials, standards that

people trust for decisions to approve or deny care, contracts with providers, and simplified standard reference coverage contracts.

NECESSARY ROLE FOR GOVERNMENT

There are several areas in which government intervention is required, where purchasers, competitors, and the industry can not or do not satisfy desired goals. Some of the essential roles of government include: (1) defining and securing rights through a publicly accountable process; (2) consumer protection including clarification and enforcement of insurance contracts and setting and enforcing broad quality standards; (3) helping the market work well by providing incentives for pooling health risks, creating an information infrastructure for medical outcomes and provider credentialing, securing the timely production of accurate quality and performance data for consumers and purchasers, enacting basic structural reforms such as creating competition at the delivery system level, taking anti-trust actions where necessary, and refraining from imposing rules that create artificial entry barriers to new health plans; and (4) subsidizing public goods.

INAPPROPRIATE ROLE FOR GOVERNMENT

Government should not attempt to micro-manage medical care, such as by prescribing lengths of hospital stay or appropriateness of outpatient surgery. Unless practices clearly threaten health and safety, government ought to stay out of regulation of the details because (1) technology is changing too rapidly for legislation and regulation to keep up, and (2) we badly need cost-reducing innovation, a process that regulatory involvement can hinder by freezing present practices in place.

In evaluating proposed consumer protections, one should be sure the alleged problem or abuse actually exists in practice, that the benefits of the proposed protection outweigh the costs, and that what is being proposed is consumer protection and not provider protection.

CONCLUSION

Government need not and should not attempt to regulate the health care industry alone. Structuring the financial incentives appropriately is the most powerful form of regulation. Purchasers, competitors, industry, and government together can structure an appropriate set of incentives that will create accessible, quality health care for consumers.

BALANCING PRIVATE AND PUBLIC SECTOR ROLES

I. INTRODUCTION

Government regulation is one of many tools for making the health care system function effectively to ensure high quality, cost-effective care to Californians. Purchasers and competitors driven by consumer preferences based on information and appropriate incentives also regulate the industry as does the industry itself through self-regulation. By recognizing the strengths and weaknesses of other mechanisms, government can more effectively direct its efforts to intervene when and where needed to achieve desired goals.

II. PURCHASERS AND COMPETITORS: REGULATORS OF FIRST RESORT

In general in our society, we look to responsible purchasers and competing sellers to allocate resources. We associate competition with quality improvement, customer service, cost reduction and desirable innovation. Large purchasers (such as the California Public Employees Retirement System (CalPERS), the Pacific Business Group on Health (PBGH), the Health Insurance Plan of California (HIPC), and the University of California (UC)) are able to use their substantial expertise and negotiating power to deal effectively with some of the major concerns in our health care system. Cost and access to doctors and specialists of one's choice are two clear examples of where large purchasers have had success. For example, managed care organizations have been innovating with new products offering wider access to specialists, or point-of-service options for access to doctors outside a managed care network that are more acceptable to many consumers.

Since 1992, premiums in California have been stable as a result of competition and the shift to managed care. Nationally, employers' average total premiums increased by just 0.5 percent in 1996.[1] The 1997 CalPERS premiums are about the same in dollars as they were in 1992 for essentially the same standard benefit package, and inflation-adjusted, they are down about 13 percent. If 1987-1992 trends had continued to 1997, CalPERS premiums would now be more than twice what they are, at a cost to employees or taxpayers of $1.5 billion per year or $4300 per employee. Most other California employment groups have experienced similar savings.

Well-organized, large purchasers have significant tools to make the market work better for consumers–tools that they have used only to a limited degree so far. The list includes:

- Creating equitable rules within which health plans must compete;
- Expanding multiple choice of plan at the individual level;
- Providing an incentive for health plans to offer value-for-money by (1) standardizing coverage contracts or significantly reducing market segmenting variation within sponsored groups to combat segmentation and to lower switching costs, (2) allowing

[1] KPMG Peat Marwick, *Health Benefits in 1996*, Tysons Corner, VA, October 1996. Average total premiums are for employers with 200 employees or more.

individuals to keep the full savings when they choose a plan with a lower premium, (3) creating a "Super Directory" of doctors and hospitals (e.g., HIPC) so people can easily look up their preferred doctors and pick the lowest-priced HMO offering them;
- Obtaining and publishing quality-related information that is usable by consumers to make better decisions and by clinical providers to improve their medical results; and
- Risk-adjusting premiums (e.g., HIPC) so that plans and providers have financial incentives to care for even the most sick among us, reducing risk-skimming behavior.

A variety of entities can manage health plan competition, and are doing so. Large pooled entities, such CalPERS with one million lives, achieve attractive pricing and economies of scale in administration. However, very large entities may create welfare losses through homogenization if covered beneficiaries have different needs and wants. Smaller pools focused on needs of different groups, such as large employers in PBGH or university employees in UC, might be more efficient and flexible.

A. Government, the Largest Purchaser

Of course, governments are also major purchasers of health care coverage. In 1995, government paid for 46% of health care services in the US so its purchasing power, as well as its obligation to beneficiaries and taxpayers, is enormous. Government has a mixed record as a purchaser from the point of view of making the health care market work for consumers, but could use its power to improve the functioning of the industry and market, e.g., as it did for small groups of 2-50 employees in California by creating the HIPC. Steps that would influence the marketplace include adoption of the purchasing cooperative model for Medicare and Medicaid.

B. Market Failure and the Need for Collective Action

Health care and health insurance markets work better today than several years ago, particularly for large employers and purchasing coalitions. Nevertheless, they are still prone to fail for many in the population, and it is still difficult even for large purchasers to get the kinds of cost reductions and quality and service performance increases they believe are possible. In part, this failure stems from many of the special characteristics of health care and health insurance, such as the incentive effects of health insurance that undermine cost-consciousness, the very high cost and asymmetry of information (doctors know important information patients do not have and vice versa), and wide variation in medical risks that makes pooling difficult. Under the prevailing premium payment system which is not risk adjusted, insurers have incentives to and thus seek to avoid insuring people who are likely to need costly medical care. In an unregulated market, such people (eventually most of us) would be unable to obtain coverage at an affordable price. In response, our society has developed mechanisms to require the pooling of medical risks, some employer-based, some legislated as in the case of risk pooling for small groups. In California, the law requires that health insurers price premiums to small groups within a narrow range around an average price to spread health cost risks.

1. Moral Status of Health Care

Market failure in health insurance is an important public policy problem because health care has a special moral status. Most people consider it unacceptable for people to suffer, to be disabled or to have shortened lives for lack of ability to pay for medical care. Nor should individuals be financially bankrupt due to a health condition. It is (or ought to be) unacceptable for children to fail to reach their potential for lack of health services that could improve their development. In a sense, universal access to necessary health care is a public good. Thus, any realistic discussion of regulation of health insurance and health services must be in the context of widely supported social goals: insurance should be widespread if not universal, affordable, and its distribution should be tolerably equitable. Because of the moral imperative, collective action at some level is needed to make access and coverage widespread and to make the market work with tolerable efficiency.

2. Lack of Information and Individual Choice

In the California market, two important reasons that purchasers and competitors are not better serving covered employees are (1) a lack of relevant information for providers, purchasers, payors, and consumers, and (2) a lack of choice, for many consumers, of managed care plans that reflect their preferences for coverage type and specific providers. Purchasers and competitors would work better as regulators if California developed a strategy to enhance consumer choices and improve information for all participants.

3. No System is Perfect

It is important to keep in mind that even if collective action could fix all existing market failures, some people would still be unsatisfied with the outcome, especially because of limitations of medical technology and the fact that insurance limits their financial responsibility so they do not have to match their wants with their own financial capabilities. In addition, there will continue to be mistakes and insensitive behavior because the system is changing rapidly. Not even the best functioning market can eliminate dissatisfaction completely.

III. INDUSTRY SELF-REGULATION

The HMO industry needs public confidence. The wiser of its leaders recognize this. The industry, on its own initiative, or in response to problems identified by employers, consumers, and regulators ought to develop improved industry standards. Areas calling for improved standards include a better definition of covered emergency treatment and other standard terminology, more reliable and effective appeals processes in case of treatment denials, standards that people trust for decisions to approve or deny care, contracts with providers, and standard reference coverage contracts.

Assurance of continuity of care following provider contract termination is one example of an area appropriate for the industry to address. People should not find part way into the contract year that, due to a contract termination, they can no longer obtain covered services from the providers they had been told would care for them when they signed up with their health plan. The industry ought to be encouraged by purchasers and, if necessary by regulators, to come up with good ideas for resolving this and similar issues.

Preferably, standards would be developed in collaboration with major purchasers (to be sure standards are not adopted that raise costs unnecessarily because such costs would inevitably be passed on to workers and taxpayers) and with broadly-based consultation with consumers.

There is a history of such self-regulation in the securities industry and in the accounting profession. The Financial Accounting Standards Board or FASB is a private profession-sponsored organization whose findings are usually ratified by the Securities and Exchange Commission. The code of conduct recently negotiated between leading American apparel manufacturers and labor and human rights advocates regarding acceptable standards for working conditions in factories in third world countries is another good example. The level of the standards and the degree of compliance achieved by appealing to the manufacturers' best values and desire for a good reputation may well exceed what would be achievable by a legal battle to legislate a standard and force compliance.

The American Association of Health Plans (AAHP) has developed a standards initiative called Patients First, and a cooperative group consisting of the American Association of Retired Persons, Families USA (a consumer advocacy group), and several non-profit HMOs have proposed Principles for Consumer Protection. These may help create new standards for industry practice. Such standards might be ratified by legislation or regulation to make them applicable to all health plans. It is very much in the industry's self-interest to do this; HMOs do not need to outrage the public to make a reasonable rate of return.

IV. NECESSARY ROLE FOR GOVERNMENT

There are several areas in which government intervention is required, where purchasers, competitors, and the industry can not or do not satisfy desired goals. Some of the essential roles of government include interpretations and enforcement of rights, consumer protection, enforcement of contracts and dispute resolution, and helping the market work well.

A. Define and Secure Rights Through a Publicly Accountable Process

This must be done while coming to terms with the inescapable fact that health care resources are limited and that society has other legitimate uses for its resources. Government has been active in defining and securing rights such as to free expression of medical judgments by doctors, to information about how plans operate, to timely, fair, and effective grievance processes and dispute resolution procedures, to timely payment for care for emergencies, and to confidentiality of personal medical records. In several of these areas, there is a need for careful balancing. For example, protection of confidentiality needs to be balanced against the legitimate and important needs for research on the relationship between treatments and outcomes to find out what medical treatments work best.

B. Consumer Protection

One of the most fundamental tasks of government is to create the conditions for markets to serve consumers well. These conditions include the rule of law, including securing property rights and defining liability, contract enforcement, anti-trust and a regulatory scheme that fits the needs of each market. Well-conceived rules can help markets work better and increase satisfaction all around. For example, the rule that permits airlines to overbook, and then auction vouchers to induce volunteers to take later flights creates a "win-win" situation.

1. Insurance Contracts

The complexity of health insurance contracts makes necessary special rules to ensure there is a meeting of minds between buyers and sellers, what is being sold is what is being delivered. There must be rules and processes that lead to the reasonable expectations of reasonable persons being met. For example, difficult as it is, there needs to be some definition and standard regarding the "medically necessary" care HMO contracts promise to deliver. Similarly, we need definitions and standards for coverage of emergencies and urgent out of network care and "experimental or investigational" services that are to be excluded from coverage. In each case, there must be a fair, efficient, and authoritative process for resolving the inevitable disputes that the imprecision of these concepts generate. Similarly, standards should govern travel time and access, i.e. definitions of what "providing services" means. Material information, such as physician payment methods and incentives schemes, should be disclosed. And enforced curbs should restrain deceptive practices. Industry-wide standard definitions and rules will help people switching among HMOs to understand the choices.

Large purchasers such as PBGH, CalPERS and the University of California have the resources to negotiate contracts that are satisfactory to their beneficiaries, but non-pooled small businesses and individuals do not. State regulators have stepped in and must step in to protect small purchasers.

2. Quality Standards

In general, regulators and large purchasers should focus on managed care deliverables rather than the delivery process in order to preserve maximum opportunity for efficiency-improving innovation. They should refrain from regulating details that might

freeze into place inefficient practices or create a pork barrel of preferences for provider groups. However, broad standards of operation are not inappropriate. Such a list would include standards for quality assurance and utilization management systems, rules to assure that medical decisions are made by qualified physicians, rules to assure no interference with doctor-patient communication about treatment options, and curbs on schemes that give doctors incentives to deny necessary treatment. Many of these protections now exist in California's Knox Keene Act.

Advocacy groups for the poor and disenfranchised are natural allies in the government's efforts to protect consumers; regulators should view them as such. On the other hand, government should not be lured into protection of the economic interests of either financial intermediaries or of provider groups under the guise of consumer protection or otherwise. Such economic protection can become self-perpetuating and self-enhancing, as we are seeing. Only the economic status of vulnerable populations–the aged, disabled, handicapped, poor, and ill–should be protected.

C. Help the Market Work Well

1. Pooling of Risks

In a system that is based on voluntary insurance, with a large proportion made up of individuals and small groups, government action is needed to require or encourage the healthy to subsidize the sick. Three main ways this is done in our society are public programs supported by taxes such as Medicare and Medicaid; employment-based health insurance which is motivated by the incentives in the exclusion of employer paid health insurance from taxable incomes of employees; and state laws limiting the variation in small group premiums.

If everyone could obtain coverage through a large employer or purchasing group that organized and managed a choice of health coverage options for group members, the market would be likely to provide a satisfactory result. However, much of the population works for small employers or is self employed, unemployed, early retirees, part time workers, etc. and does not have access to purchasing groups. Nor are purchasing groups currently growing and forming rapidly enough to provide access for everyone in the foreseeable future. State and private entities have attempted to form purchasing groups, so far with limited success. Additional collective action is needed, for example, in the form of purchasing groups that pool the risks of many small employers, and incentives for small employers to join a group.

Because, like individuals, small groups of healthy individuals prefer not to subsidize the costs of small groups that include sick or high risk individuals, it is difficult to pool small groups on a purely voluntary basis. Where large purchasers or purchasing groups are not accessible, government can either encourage purchasing through pooled arrangements and the formation of new purchasing entities, e.g., through subsidies, or can act as purchaser or sponsor itself.

2. Creating an Information Infrastructure

Government action is required to create an information infrastructure for medical outcomes evaluation and provider credentialing. The significant cost of this project makes successful private initiative unlikely without government leadership and help.

3. Enabling Comparative Information

Government action is needed to secure the timely production of accurate quality-related data and health plan performance data that consumers and purchasers need to make well-informed decisions. Data needed for risk-adjusted medical outcomes studies, by hospitals, health plans, and providers in California is lagging behind other states. Government is needed to secure publication of information on how health plans work.

Government might help to lead the whole health services industry in the development of uniform data standards for reporting about prices, performance, quality, and service and for comparative evaluation studies. Government should coordinate these efforts with and build on local private, national, and international efforts to set and promote data standards which are a prerequisite to generating adequate information on the basis of which to judge health plans and providers.

4. Enacting Structural Change

Collective action may be required to enact basic structural reforms, such as creating competition at the delivery system level where quality is determined and where most costs are generated, rather than just at the health plan level. Cost, complexity, and frustration among providers are increased by the fact that many medical groups must deal with more than a dozen carriers, each with its own referral, approval, and reporting procedures, formularies, etc. Incentives for a health plan to invest in the information systems of medical groups are attenuated by the fact that the benefits will be shared by a dozen other carriers. A fundamentally simpler, possibly more effective, system would be based on competing "delivery system HMOs", each with a mutually exclusive relationship between a provider group and a health plan. Collective action might help move us to such a system by easing market entry by delivery system HMOs and by assuring that each consumer has a wide range of choice of provider organizations so that she can enroll with the providers she prefers without the need for each HMO to have an all-encompassing network.

5. Considering Antitrust Actions

Where necessary, government must take anti-trust actions to prevent business combinations or actions that block competition. There have been several large mergers among California HMOs recently which have received, and apparently passed, anti-trust scrutiny. However, those conducting the analysis and making the decisions face a significant challenge to understand the implications of a market changing so rapidly.

6. Preventing Entry Barriers

It is important to be sure that government does not inadvertently create artificial barriers to market entry by new health plans. For instance, the time and cost for DOC approval of a new Knox-Keene license have been reported to be very substantial, and DOC's requirement for contiguous expansion makes growth more difficult. These requirements

lead some to seek less onerous regulation under the Department of Insurance. Consumers pay for entry barriers.

D. Subsidizing Public Goods

Public goods are goods that benefit everyone and from which free riders cannot be excluded. They cannot be allocated in the marketplace or would be under-produced in a purely private market. In health care, government has a central role in subsidizing the public goods of education, research, care for the poor and uninsured, public health initiatives such as epidemic control, and information (for example, hospital reporting to support risk-adjusted measures of outcome) that are not adequately provided for in the private market.

V. INAPPROPRIATE ROLE FOR GOVERNMENT

A. Legislative Tampering

The legislature knows little of the complexities of medical organization and should not mandate its details. Government should not attempt to micro-manage medical care, such as by prescribing lengths of hospital stay or appropriateness of outpatient surgery. Unless practices clearly threaten health and safety, there are good reasons for government to stay out of regulation of the details. First, technology is changing very rapidly, yet legislation and regulation tend to freeze things into place. Laws create vested interests who fight hard to prevent change. Second, we badly need cost-reducing innovation, a process that regulatory involvement can hinder. For example in 1996, the issue of length of stay for normal uncomplicated deliveries was politicized, and in the excitement, Congress lost sight of the cost of longer stays, the possibility of less costly alternatives to assure proper follow-up care (e.g. home visits by nurses as in the United Kingdom), and the absence of evidence of medical benefit. Perfectly safe, cost-saving innovations will be discouraged if the innovators risk denunciation for symbolic political purposes. Third, these complex issues require judgment based on years of medical training, experience, and study of scientific data that most legislators and regulators do not have the time to master. Fourth, some recent legislative and regulatory actions, while ostensibly protecting patients, deny people the opportunity to choose a safe but less costly form of medical practice, which unfairly imposes some people's preferences on others. Finally, nearly 1000 State benefit and provider mandates on health insurance[2] have caused employers to retreat to self-funded plans protected from state regulation by the Employee Retirement Income Security Act of 1974 (ERISA). According to research, such mandates add up to 20 percent to the cost of premiums and thereby increase the number of uninsured. These mandates were promoted more by provider interests than consumers.

B. Criteria for Evaluation

Evaluating proposed consumer protections, should include the following criteria. First, one should be sure the alleged problem or abuse actually exists in practice and is not merely hypothetical or an aberration. Second, because workers and taxpayers and not health plans will ultimately bear the costs, the benefits of the proposed protection should

[2] "State Mandated Benefits and Providers, December 1996" and "Cost of State Mandated Health Benefits, December 1992", Blue Cross Blue Shield Association.

outweigh the costs. Third, one should be sure that what is being proposed is consumer protection and not provider protection masquerading as consumer protection.

VI. CONCLUSION

Government need not and should not attempt to regulate the health care industry alone. The basic rule of economics and of human nature is that behavior, even of those involved in providing health care, is influenced by where the resources and other rewards can be found. Structuring the financial incentives appropriately is the most powerful form of regulation. Purchasers, competitors, industry, and government together can structure an appropriate set of incentives that will create accessible, quality health care for consumers.